RI Department of Health

Application and Instructions for:

Certified Food Safety Manager

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Applicant Name

OFFICE USE ONLY

	Initials	Date
Approved by F.O. Supervisor		
Profile Entered By		
License ID#		
Receipt No.		
License No.		

INSTRUCTIONS

- Registration shall be based upon **Satisfactory Compliance** with all applicable laws and regulations.

- Registration forms must be either typed or legibly printed using a ballpoint pen, except signatures, which must be written in ink. Please answer all questions. Do not leave blanks. Incomplete applications will be returned to you and your license/permit will not be issued.

- Attach check/money order to the front of this application and mail or hand deliver to: Office of Food Protection, 3 Capitol Hill, Room 203, Providence, RI 02908-5097. A receipt or cancelled check does not guarantee licensure.

Application Fees:

Food Safety Manager $36.00

- Make your check/money order payable to "General Treasurer, State of Rhode Island". Do not send cash. This fee is non-refundable.

- If you have any questions concerning this application, call the Department of Health, Office of Food Protection at (401) 222-2749.

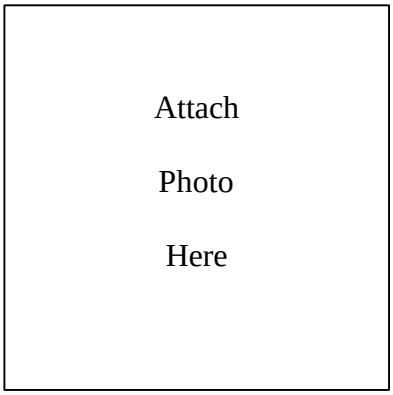
- Licensure application materials are public records as mandated by Rhode Island law and may be made available to the public, unless otherwise prohibited by State or Federal law.

NOTE: If you are a State or Municipal Employee, This is the **WRONG** application. Please contact the Office of Food Protection at the above number for the correct application.

REQUIRED ATTACHMENTS:

Please enclose a copy of your birth certificate or copy of your driver's license.

Please attach a recent identification photograph in the space provided below:



State of Rhode Island and Providence Plantations
Department of Health
Office of Food Protection

Name: This is the name that will be printed on your License and reported to those that inquire about your License. Do not use nicknames, etc.	Name: _____
Social Security Number:	_____ - _____ - _____
Gender:	☐ M ☐ F
Date and Place of Birth:	Date _____ / _____ /_____ Place _____ City State
Residence Information: It is your responsibility to keep the Department apprised of all address and phone number changes. **(Not published on the HEALTH web site**).	Address Line 1 _____ Address Line 2 _____ Address Line 3 _____ City,State, ZipCode _____ Country (only if not in US) _____ Phone: _____ Fax: _____ Email Address: _____
Business/Employment Information: Please provide the employment information related to <u>this</u> license. Include Name of Business/Employer (ie. Memorial Hospital) (**Published on the HEALTH web site**).	Facility Name _____ Facility License Number _____ Address Line 1 _____ Address Line 2 _____ Address Line 3_____ City,State, ZipCode _____ Country (only if not in US) _____ Phone:_____ Fax: _____ Email Address: _____
Business/Employer License Number: **MANDATORY**	Please provide the RI Department of Health License Number of the Business where you will be working. (FSV/MRK) _____

Preferred Mailing Address: Please check ONE (Published)	☐ Residence Address ☐ Business/Employment Address
Education Information:	Did you complete a fifteen (15) hour Division approved Food Safety Training Course? ☐ Yes ☐ No
NOTE: You must enclose a copy of course completion certificate or RECIPROCITY APPLICANTS enclose equivalent educational credentials or certification credentials from participating agency.	Did you pass the Food Protection Certification Monitored Examination? ☐ Yes ☐ No If Yes, Course Location _____ Instructor License # _____ Name of Testing Company _____ Date of Examination _____ Certificate No. _____

Disciplinary Actions

Check either "Yes" or "No" for each question. NOTE: If you answer "YES" to any question, you are required to furnish completed details, including date, place, reason and disposition of the matter.

Disciplinary Question A	Have you ever been convicted of a violation of, or pled Nolo Contendere to any Federal, State or local statute, regulation or ordinance, or entered into a plea bargain related to a felony, (including convictions for driving under the influence), or related to the manufacture, distribution, possession, prescribing, administering or dispensing of drugs presently defined as controlled substances under (Chapter 21-28) of the General Laws of Rhode Island? ☐ Yes ☐ No
Disciplinary Question B	Have you ever had a membership in a professional society revoked, suspended, or limited in any manner or have you voluntarily withdrawn while under investigation? ☐ Yes ☐ No
Affidavit of Applicant Read, sign and date this Affidavit.	**AFFIDAVIT AND SIGNATURE** **This Application Must be Signed** **I have read carefully the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my License in the State of Rhode Island.** **I understand that this is a continuing application and that I have an affirmative duty to inform the Rhode Island Department of Health of any change in the answers to these questions after this application and this Affidavit is signed.** **Signature of Applicant** **Date of Signature (MM/DD/YY)**

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